ORIGINAL

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
- -
ADRIAN SCHOOLCRAFT,
Plaintiff,
-against- Index No.
10CIV-6005 (RWS)

THE CITY OF NEW YORK, DEPUTY CHIEF MICHAEL MARINO, Tax Id. 873220, Individually and in his Official Capacity, ASSISTANT CHIEF PATROL BOROUGH BROOKLYN NORTH GERALD NELSON, Tax Id. 912370, Individually and in his Official Capacity, DEPUTY INSPECTOR STEVEN MAURIELLO, Tax Id. 895117, Individually and in his Official Capacity, CAPTAIN THEODORE LAUTERBORN, Tax Id. 897840, Individually and in his Official Capacity, LIEUTENANT JOSEPH GOFF, Tax Id. 894025, Individually and in his Official Capacity, stg. Frederick Sawyer, Shield No. 2576, Individually and in his Official Capacity, SERGEANT KURT DUNCAN, Shield No. 2483, Individually and in his Official Capacity, LIEUTENANT TIMOTHY CAUGHEY, Tax Id. 885374, Individually and in his Official Capacity, SERGEANT SHANTEL JAMES, Shield No. 3004, and P.O.'s "JOHN DOE" 1-50, Individually and in their Official Capacity (the name John Doe being fictitious, as the true names are presently unknown)(collectively referred to as "NYPD defendants"), JAMAICA HOSPITAL MEDICAL CENTER, DR. ISAK ISAKOV, Individually and in his Official Capacity, DR. LILIAN ALDANA-BERNIER, Individually and in her Official Capacity and JAMAICA HOSPITAL MEDICAL CENTER EMPLOYEES "JOHN DOE" # 1-50, Individually

(Continued)

and in their Official Capacity (the name John Doe being fictitious, as the true names are presently unknown),

Defendants.

- -x

111 Broadway
New York, New York
February 11, 2014
10:30 a.m.

VIDEOTAPED DEPOSITION of DR. LILIAN ALDANA-BERNIER, one of the Defendants in the above-entitled action, held at the above time and place, taken before Margaret Scully-Ayers, a Shorthand Reporter and Notary Public of the State of New York, pursuant to the Federal Rules of Civil Procedure.

* * *

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(Appearances continued on next page.)

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(Appearances continued on next page.)

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File # 090.155440

ALSO PRESENT AT VARIOUS TIMES: MAGDALENA BAUZA

* * *

STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED, by and among counsel for the respective parties hereto, that the filing, sealing and certification of the within deposition shall be and the same are hereby waived;

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to form of the question, shall be reserved to the time of the trial;

IT IS FURTHER STIPULATED AND AGREED that the within deposition may be signed before any Notary Public with the same force and effect as if signed and sworn to before the Court.

* * *

MR. SMITH: On the record at 10:29. We are starting the deposition of Dr. Lilian --

MR. CALLAN: Aldana, A-L-D-A-N-A, Bernier.

MR. SMITH: Aldana-Bernier.

The deposition is being videotaped.

We are at 111 Broadway, my office, Nathaniel Smith, and today is the 11th of February 2014.

You can swear the Witness in.

L I L I A N A L D A N A - B E R N I E R, the Witness herein, having first been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY MR. SUCKLE:

Q. What is your name?

A. Lilian Aldana, hyphen, Bernier; L-I-L-I-A-N, A-L-D-A-N-A, hyphen, B-E-R-N-I-E-R.

Q. Where do you reside?

A. 71 Parker Avenue, Maplewood, New Jersey 07042.

L. ALDANA-BERNIER

Q. Good morning, Doctor. My name is Howard Suckle. I represent Mr. Schoolcraft in this matter, and I'll be asking you some questions today.

Although I'm sure your attorney has gone over some basic rules of a deposition, let me just make sure we are all are clear on them.

If at any time you don't understand my question for any reason whatsoever, please let me know because if you do answer we are going to assume that you understood the question. Okay?

A. Okay.

Q. In addition while sometimes during the course of a conversation, a shake of the head or a nod may be an appropriate answer when the answer is yes or no. Here we have a court reporter and the court reporter needs to take down everything that you say, everything I say, and anything else said in the room.

If the answer is appropriately yes or no, can you please use some type

of word, say yes or no, opposed to shaking your head?

A. Yes.

Q. Also in that vein, the reporter needs to take down everything that you and I say. Although you may anticipate what my question is going to be before I finish, please let me finish it so the reporter can take that down and then begin to answer. Okay?

A. Yes.

Q. Doctor, can you tell me what you presently do for a living?

A. I am a medical doctor, psychiatrist specialty.

Q. Where are you employed, if at all?

A. I am. I'm working for Jamaica Hospital.

Q. When you say you work for Jamaica Hospital, is that your employer?

A. Yes.

Q. How long have you been employed by Jamaica Hospital?

A. From 1995 to the present.

Q. I don't want to know the details, but you are paid a salary, correct?

A. Yes.

Q. By Jamaica Hospital?

A. Yes.

Q. In other words when you see patients, you don't bill them independently, do you?

A. No, I don't.

Q. Doctor, can you tell me where did you go to undergraduate school?

A. I went to the Concordia College. That is for my BSN in the Philippines.

Q. Are you originally from the Philippines?

A. I am from the Philippines, yes.

Q. That's where you were born?

A. Yes.

Q. What did you study at Concordia College?

A. That's bachelor's of science in

L. ALDANA-BERNIER

nursing.

MR. SMITH: Sorry. What was that bachelor's in?

THE WITNESS: In nursing.

Q. When did you complete that?

A. This was in 1973.

Q. After you completed your bachelor's in nursing, what did you do with regards to your career or education?

A. When I finished in March, I work in the emergency room voluntarily for the Far Eastern University.

Q. How long did you do that?

A. From March to November when I came to the United States in 1973.

Q. When you came to the United States, for what purpose did you come to the United States?

A. The American dream.

Q. Did you continue your education or your career at that point?

A. Yes, 1976 to '97 I took my master's in nursing, minor in education at the New York University.

L. ALDANA-BERNIER

Q. So you have a master's in nursing?

A. Yes.

Q. And education?

A. Yes.

Q. After you completed your master's in nursing and in education, what did you do next with regard to your career and education?

A. After that I went to medical school from 1981 to 1986, University of Santiago, Dominican Republic.

Q. At some point you immigrated to the Dominican Republic?

A. Yes.

Q. Did you become a citizen of the Dominican Republic?

A. No, I was a citizen of the United States before I went there.

Q. Just for the record, when did you become a citizen?

A. That was between '78 and '79.

Q. While you were in medical school, did you concentrate on any

particular area of medicine?

A. At that point in medical school, no.

Q. Did you graduate from the University of Santiago?

A. Yes.

Q. What was your degree?

A. MD.

Q. What did you do next after that with regard to your career or education?

A. In 1986 I had my externship at the Elizabeth General Hospital in psychiatry.

Q. Where is that?

A. In New Jersey.

Q. How long did you do that?

A. For a year.

Q. After that what did you do next with regard to your career or education?

A. From '89 to '93, I had my residency in psychiatry at the Metropolitan Hospital here in Manhattan.

Q. As a resident did you have to rotate through other disciplines as well

as psychiatry?

A. Yes, we did internal medicine, urology.

Q. Any other disciplines you rotated through?

A. I choose my elective in endocrine.

Q. What is endocrine?

A. Endocrine has to do with your hormones.

Q. Did you complete that residency?

A. I did in 1993.

Q. After your residency what did you do next with regard to your career or education?

A. After 1993 I had -- 1994 I work at Kings County Hospital as an inpatient doctor.

Q. When you say "inpatient doctor," what do you mean?

A. Inpatient unit.

Q. In psychiatry?

A. Psychiatry inpatient unit.

L. ALDANA-BERNIER

Q. As an attending?

A. Attending.

Q. You were employed by Kings County Hospital?

A. Kings County Hospital.

Q. That's a hospital run by the City of New York?

A. Yes, Brooklyn.

Q. You were an employee of the City of New York at that time?

A. Yes.

Q. We're early on now, and it's okay, but if we keep running over each and you're not letting me finish before you answer, she is going to start hitting me.

You have to let me finish before you answer. Okay?

A. Okay.

Q. How long were you an employee of the City of New York?

A. Can I count?

Q. Take your time.

A. I'm not sure. Between eight to

nine months.

Q. While you were doing your residency at Metropolitan, is that a City hospital?

A. It's a City hospital.

Q. While you were there, were you paid any money or given any stipend?

A. Paid a salary.

Q. So you were an employee at that point too of the City of New York, correct?

A. Yes.

Q. How long were you an employee of Metropolitan?

A. Four years.

Q. After the inpatient attending at Kings County Hospital, what did you do next?

A. I went to Coney Island emergency room.

Q. What did you do there?

A. Emergency room attending.

Q. Psychiatric?

A. Psychiatric emergency room.

L. ALDANA-BERNIER

Q. Is Coney Island Hospital a City hospital?

A. City hospital.

Q. How long did you work as an attending at the Coney Island Hospital for the City of New York?

A. At the time maybe three months.

Q. When you went from Kings to Coney Island Hospital, was this a transfer; did you leave one job and start a new job?

A. I left one job to start a new job.

Q. After what year was it that you worked at Coney Island Hospital?

A. That was 1995.

Q. After Coney Island Hospital, what did you do next?

A. I went to Jamaica Hospital.

Q. So you went to Jamaica Hospital in 1995?

A. '95.

Q. And you have been employed there ever since?

A. Yes.

Q. When you first got to Jamaica Hospital, what was your position?

A. I was working in the emergency room as an attending psychiatrist.

Q. And has that position changed at all, have you changed your position at Jamaica Hospital?

A. As an attending? I'm still an attending.

Q. You are still in the same position as in 1995?

A. I'm an attending still in Jamaica Hospital.

Q. Were you anything other than an attending at Jamaica Hospital?

A. I was director of the emergency room.

Q. When were you the director of the emergency room?

A. I am not sure. I don't remember when, but I was acting director and became the director. Then I was still an attending at Jamaica Hospital.

Q. How many months or years were you the acting director?

A. How many years?

Q. How long?

A. Like -- I have no recollection.

Q. Was it a year, two years, six months, ten years? Give me an idea.

A. As acting, approximately one year.

Q. How about as director?

A. Director, maybe ten years.

Q. While you were the acting director and director, were you actually practicing medicine during that period of time?

A. Yes.

Q. Well, was there any difference in the job function as acting director or director?

A. No. They were trying to find something so you are just the acting until they find a real director.

Q. And they found you?

A. Yeah, I have been there. They

rather have somebody in there than take somebody from outside.

Q. When was the last time you were in the role of director of the psychiatric emergency room at Jamaica Hospital?

A. That was October 2013.

Q. So in October 2009, you were the director of the psychiatric emergency room?

A. Yes.

Q. As a director of the psychiatric emergency room in October 2009, what were your responsibilities and functions?

A. Director of emergency room, you do have administrative responsibility. You attend administrative meeting. At the same time, you were still do clinicals, you still have the clinical aspect. You have to see the patients. At the same time, you have to oversee the residents and the other staff of the emergency room.

L. ALDANA-BERNIER

Q. As the director of the emergency room, did you have any role in creating or drafting any of the rules or regulations of Jamaica Hospital emergency room?

A. Together with the other members of the team or other administrators, yes, I sit down with them and give my feedback.

Q. How much of your job in October 2009 as director involved administrative work versus clinical work?

A. I do more clinical.

Q. You say more clinical?

A. More clinical, yes.

Q. Give me an idea how much of your day or week was spent doing administrative work versus clinical work?

A. I do more clinical, but I was the only psychiatrist in the emergency room until -- go ahead?

Q. Until when?

A. Until they had given me a new attending which was for only one year.

L. ALDANA-BERNIER

Q. When was that?

A. In 2012/2013.

Q. So October 2009 you were the only attending psychiatric physician in the psychiatric emergency room?

A. Yes.

Q. And did you have a set schedule at the time during the day that you worked?

A. I go to work from eight o'clock.

Q. Until when?

A. That depends, until finishing my patient. I cannot stay because sometimes you work overtime, six o'clock, seven o'clock.

Q. What is the standard day?

A. Eight to four.

I want you to know, I don't stay until four o'clock. I stay more than that.

Q. That's what I'm trying to find out.

On an average day, if there is

such a thing, how long do you stay at the hospital?

A. Maybe ten, 12 hours.

Q. When I talked about administrative responsibilities, to oversee the residents, was that part of that administrative responsibility, is that clinical, or something else?

A. That's more of your teaching responsibilities.

Q. How about overseeing the staff, is that in addition to your administrative responsibilities?

A. Yes.

Q. How much of your time was devoted to doing clinical compared to all of these other functions that you had as director?

A. I spend maybe out of the ten hours, I spend eight hours clinical.

Q. When you say "overseeing staff," is that the nursing staff or something else?

A. Yes, nursing staff.

L. ALDANA-BERNIER

Q. In addition to having been the only psychiatric physician employed at the emergency room in October 2009, were there other physicians who had privileges in the emergency room; psychiatric I'm talking about?

A. Yes.

Q. And how did that work, what kind of association did other doctors have with the psychiatric emergency room that you are aware of?

A. We divided in shifts. One you have that works from four to 12 and one that work from 12 to eight.

Q. When you say "one that works," since you were the only one employed, what was the title of the people that worked for the other two shifts?

A. Also psychiatrists.

Q. Were they employed by Jamaica Hospital?

A. Yes.

Q. And that was in October 2009?

A. Yes.

L. ALDANA-BERNIER

Q. Let me just clarify: I thought you said you were the only psychiatrist working in the emergency room in October 2009. Are you saying these other psychiatrists were residents?

A. I'm referring to the time you were asking. The time I work from eight to four, I am the only psychiatrist.

Q. So during your shift?

A. During my shift.

Q. In October 2009 who were the other psychiatrists employed by Jamaica Hospital that you are aware of in the emergency room?

MR. RADOMISLI: Objection to form.

A. When you saying other psychiatrists, include the residents?

Q. Let's not talk about residents yet. The other attendings.

A. Who are the other?

Q. Yes, who are the other physicians that man those other shifts?

A. I will not remember who those

L. ALDANA-BERNIER

psychiatrist were.

MR. SMITH: What was the answer?

MR. CALLAN: She doesn't remember.

[The requested portion of the record was read.]

Q. And working at Metropolitan, Kings County Hospital, Coney Island Hospital up until your job working with Jamaica Hospital, did you ever encounter patients brought in by police officers to the emergency psychiatric unit?

A. Did I ever encounter?

Q. Yes.

A. In all of the hospitals that I worked?

Q. Yes.

A. Yes.

Q. From October 2009 back into your career, how many times did you encounter patients who had been brought to the psychiatric emergency room by police officers?

A. I will not remember.

L. ALDANA-BERNIER

Q. Hundreds of people, thousands of people?

A. Not hundreds.

Q. How often in your career have you encountered patients brought to the psychiatric emergency room by police officers?

A. Repeat that question.

Q. Sure.

In your career how many times have you encountered patients being brought to the emergency room by police officers?

A. I think I answered you. I will say I cannot remember.

Q. Can you give me an estimate what kind of number we are talking about: ten times, five times, a hundred times?

A. Well, I will be deceiving you if I told you a number, right?

Q. Can you give your best estimate?

A. Maybe ten.

Q. In those ten or so times,

understanding it's an estimate, do you recall any of those patients being brought in in handcuffs?

A. Okay. How do you want me to answer that?

Q. Yes or no.

Do you remember anybody, any of those ten or so people, being brought in in handcuffs?

A. They were -- any time an officer bring a patient, they are in handcuffs.

Q. Every single time that you encountered officers bringing patients to the hospital, they are in handcuffs in your history?

A. When an officer brings a patient to the emergency room, they usually are in handcuffs.

Q. And they are usually under arrest?

A. Not all are under arrest.

Q. When you say "they are not all under arrest," what do you mean?

L. ALDANA-BERNIER

A. When they bring in a patient very agitated, combative, violent, depending on the nature of their call, I'm sure they were being brought by handcuffs.

Q. And do you recall as you sit here any of names of any of those patients?

A. No.

Q. And do you recall as you sit here a gentleman named Adrian Schoolcraft from only your memory?

A. Hold on. You're saying from my memory?

Q. Yes.

A. Because I have been reading the chart.

Q. Independent of the records, do you have any memory of Adrian Schoolcraft?

MR. CALLAN: Objection to the form of the question.

You can answer.

A. No, I don't.

L. ALDANA-BERNIER

Q. Okay. Can't describe him physically, can you?

A. No.

Q. So am I correct that your entire memory of any care or treatment you may have rendered to Mr. Schoolcraft is contained in the hospital chart of Jamaica Hospital?

MR. RADOMISLI: Objection to form.

MR. CALLAN: I join in the objection.

You can answer.

A. From it, yes.

Q. So your memory of care and treatment of Mr. Schoolcraft comes from the notes contained in the hospital chart of Jamaica Hospital, correct?

A. Yes.

Q. And prior to coming here today, did you review any documents?

A. The same, yes.

Q. What did you review?

A. The records [indicating].

L. ALDANA-BERNIER

Q. When you say "the records," what records?

A. The hospital records.

Q. Of who?

A. Of Mr. Schoolcraft.

Q. Did you review the entire hospital chart?

A. Not the entire, just go through maybe five pages.

Q. What five pages did you look at?

A. Just going through [indicating].

Q. What was the nature of the things you looked at?

A. I want to the consult, and I went through the notes of the resident.

Q. Your consult and the --

A. The consult of the resident and the notes of the residents when the resident was working in the emergency room.

Q. Your consult and the resident's note in your --

L. ALDANA-BERNIER

A. Not my consult, a consult done by the resident in the medical ER and the notes of the resident when the patient was in our psych unit.

Q. The consult of the resident, was that a psych ER consult?

A. It was a psychiatric consult in the medical ER.

Q. And then you looked at notes from the psych ER?

A. From the psych ER.

Q. Were any of those your notes?

A. The notes of the residence.

Q. Prior to coming here today and since October 2009, have you ever looked at any notes that you made in the chart?

A. No.

Q. So in anticipation of coming here today before you came to this room, did you look at any documents before today?

A. Yes, same notes.

Q. Same notes.

In that entire time from

October 2009 up until today, did you have access to the entire Jamaica Hospital chart, at least as you understood it to be?

A. No.

Q. No one showed it to you?

A. No.

Q. Did you ask to review it?

A. Before, but I was stopped.

Q. Who stopped you?

A. The hospital risk management.

Q. So you at some point decided you want to look at the chart, and risk management asked you not to do that?

A. The very, very first time, yes. I don't remember when was that but was risk management.

Q. Was that when you received some type of summons and complaint regarding this lawsuit?

A. Yes.

Q. After that you knew you were coming here to testify, correct, somewhere before today someone told you

have to testify, right?

A. Yes.

Q. In fact this is the second time that you arrived in this room to testify, correct?

A. Yes.

Q. In anticipation of either of those two times, you never reviewed the chart other than the notes you --

A. You're right.

Q. You never reviewed any chart with your handwriting on it prior to today?

A. My handwriting?

Q. Yes.

A. I saw it.

Q. So you read your handwriting or your notes?

A. Yes.

Q. So now you have told me you have read the consult of a resident, psychiatric resident, in the medical ER and the notes in the psychiatric ER?

A. [Indicating.]

L. ALDANA-BERNIER

Q. And your notes?

MR. CALLAN: Those were her notes, Counsel. I think that's the confusion.

MR. SUCKLE: I'll clarify. Thank you.

A. Yes.

Q. As your counsel points out, the psych ER notes included your notes?

A. Yes.

Q. Did you make any notes in the chart that you were aware of that were not done in the psych ER?

A. No.

Q. And did you review any other documents in anticipation of coming here to testify?

A. No.

Q. Did you read any transcripts of any testimony prior to today?

A. No.

Q. Did you speak to anybody at Jamaica Hospital regarding preparing for testimony here today?

L. ALDANA-BERNIER

A. No.

Q. Have you spoken to anybody at Jamaica Hospital --

MR. SUCKLE: Withdrawn.

Q. Have you spoken to anybody at Jamaica Hospital about your care and treatment of Mr. Schoolcraft?

A. No.

Q. How about anybody else's care and treatment of Mr. Schoolcraft?

A. Who?

Q. Have you ever spoken to anybody at Jamaica Hospital about anybody else's care and treatment of Mr. Schoolcraft?

A. No.

Q. Have you spoken to anybody from the New York City Police Department regarding your care and treatment of Mr. Schoolcraft?

A. No.

Q. And just for the record, what is risk management? You said you spoke to risk management. What is that?

A. They are the legal department.

L. ALDANA-BERNIER

MR. SUCKLE: Mark this 69.

[The document was hereby marked as Plaintiff's Exhibit 69 for identification, as of this date.]

MR. CALLAN: I'll show you what's been marked as Plaintiff's Exhibit 69.

Counsel from Jamaica Hospital, is that the hospital chart provided to you by Jamaica Hospital for Adrian Schoolcraft?

MR. RADOMISLI: Yes.

Q. I will ask you, do you know what this is?

A. That's our record.

Q. When you say "our record," you mean Jamaica Hospital's record?

A. Jamaica Hospital record.

Q. That record is created as part of the business of Jamaica Hospital, correct?

A. Correct.

Q. It's the business of Jamaica Hospital to make that record?

A. You're right.

Q. And that record is kept at Jamaica Hospital as part of its regular course of business, correct?

A. Yes.

Q. And entries in this chart were made on or about the dates listed in here?

A. Yes.

Q. Is this the record that you had access to review prior to testifying here today?

A. Yes.

Q. Or a copy of it?

A. Or the copy, yes.

Q. But you did have a chance to review this original record here today prior to testifying?

A. Yes, when I came in here.

Q. Can you tell me from your review of the record before we go through the record, generally what was your role, if at all, was with regard to the care and treatment of Mr. Schoolcraft?

L. ALDANA-BERNIER

A. What was my role in the care?

Q. Yes.

A. My role was I as soon as I came to the emergency room, I had the responsibility to go and see every patient that was left over under my care and Mr. Schoolcraft was one of them so I had to, like, every other patient go and see him, speak to him, evaluate him.

Q. Evaluate him?

A. Yes.

And then I have to read the notes of the initial doctor who was the resident that saw the patient. I have to assess that note, and make my decision if needed to be admitted.

Q. In your training as a nurse, did you learn about the creation of hospital records?

A. Did I what?

Q. Did you learn about how to make hospital records in your training as a nurse?

A. How to make hospital records?

Q. Yes.

A. Yes.

Q. Did you also learn how to make hospital records during your training as a physician?

A. Yes.

Q. And as a resident, did you learn about how to make hospital records?

A. Yes.

Q. How about Kings County, did you learn there about how to make hospital records?

A. Yes.

Q. And the same for Coney Island Hospital, correct?

A. Yes.

Q. And Jamaica Hospital as well?

A. Yes.

Q. In fact do you know what the purpose of creating a hospital record is?

A. That's to keep a file on the patient.

Q. Is that just to have a file, or is there a medical purpose for creating a

hospital record?

A. Yes, a medical purpose for the file to ascertain that the patient was in that place when he was treated.

Q. Just to know whether or know he was physically in the place?

A. It's a medical record of the patient, complete medical record of the patient.

Q. When you say "complete medical record," it's supposed to show the treatment of a patient at a facility?

A. Treatment, treatment plan, and discharge plan.

Q. If there is an evaluation of the patient, the records are required to have details of that evaluation, correct?

A. Yes.

Q. If there is an examination of the patient, it's required to create notes regarding that --

MR. CALLAN: Objection.

A. Yes.

Q. Does good and accepted medical

practice require when a physician examines a patient they make a note of that examination?

A. Yes.

Q. Does good and accepted medical practice require when a physician makes an evaluation of the patient, they need to make a note of that evaluation?

A. Yes.

Q. And why do physicians make notes of their examinations of patients in hospital charts?

A. Why do we make notes?

Q. Yes.

A. We have to make notes to make sure that we have seen the patient, that we have assessed what we are supposed to be doing for the patient, and to make sure there is a record that the patient was assessed and evaluated and treated; that's why we do it.

Q. Isn't it also important to note in the records either your examinations or evaluation of a patient so that in the

future someone else can read those evaluations and examinations and understand what took place?

A. You're right.

Q. You know in medicine sometimes you are not the last physician to see a patient, correct?

A. That's right.

Q. Especially in a hospital setting?

A. That's correct.

Q. Sometimes you will evaluate or see a patient and other physicians will see a patient and evaluate them, correct?

A. Yes.

Q. And you know that other physicians may want to review what happened in the past, correct?

A. That's correct.

Q. That's one of the reasons for creating a hospital record and notes in the hospital, correct?

A. That's correct.

Q. In fact you testified that you

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went back and read some previous notes that other physicians made in Mr. Schoolcraft's chart during your care and treatment of him, correct?

A. That's correct.

Q. It's important for you to have notes from other physicians so you know what their evaluations were, correct?

A. That's correct.

Q. Also to know what their examinations were?

A. That's correct.

Q. And to know what they base their examinations and evaluations on, correct?

A. That's correct.

Q. The only way to know that would be to read the chart and see what is written down, correct?

MR. RADOMISLI: Objection to form.

A. That's correct.

Q. When you went and evaluated Mr. Schoolcraft, did you actually speak to

the residents that had written the notes that you just described?

A. I did not speak to the residents. I read his notes.

Q. You relied on the records to determine what previously had taken place with Mr. Schoolcraft; is that what you're saying?

A. I read his notes. I had to go see the patient.

Q. Do you know whether or not any physician reviewed any of your records after you treated Mr. Schoolcraft?

A. I do not know if they reviewed my records.

Q. Do you know if they did?

A. I'm sure they go and read the notes.

Q. When you examine a patient in the psychiatric ER, is that a physical examination, psychiatric examination, or something else?

MR. LEE: Objection to form.

A. Psychiatric evaluation.

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Q. Did you in October 2009 or November 2009 have a standard practice how you did a psychiatric examination?

A. Yes, yes. Evaluate the patient and get the history of present illness and the past history and then you do a mental status exam.

Q. So you do history, past history, and mental status exam?

A. Yes.

Q. And the history is gotten by asking the patient questions?

A. Yes.

Q. And any other way that you get the history?

A. It's just through interaction.

Q. With the patient?

A. With the patient, yes.

Q. So you ask a question, the patient answers, so you get the history?

A. Yes.

Q. How about the past medical history, same thing?

A. Yeah, it's history, present

illness, past history, past medical history, and the mental status exam.

Q. Everything but the mental status exam is done by asking the patient questions, getting answers, and writing it down?

A. Yes.

Q. Why did you write those things down?

A. For records so that somebody else when the next doctor comes will be able to read the notes.

Q. What is a mental status exam?

A. A mental status exam is -- entails different questions like testing cognitive function.

Q. Conative function?

A. Yes.

Testing his abstraction, testing his thought process, testing the thought content whether there is a delusion, there is a hallucination, if he was suicidal or homicidal; also includes visual assessment which is looking at his

appearance and also assessing his speech and assessing his insight and judgment.

Q. This is how you do your mental status exam on all the psychiatric patients --

A. Yes.

Q. You do your own examination, correct?

A. Yes.

Q. Let's go to testing conative functioning, how do you do that?

A. Testing orientation, checking his memory.

Q. And you ask him questions?

A. Yes.

Q. You did a mental status examination on Mr. Schoolcraft, right?

A. Yes.

Q. You asked him questions about his memory, correct?

A. We do that on all our patients.

Q. You did that on Mr. Schoolcraft, correct?

A. We do it on all of our

patients. I may have done on Mr. Schoolcraft.

Q. Any other things that you do with regard to conative function in your mental status examination?

A. Usually the orientation and the memory.

Q. When you say "orientation," what do you mean?

A. Asking what date is it today, where are you right now, if he is aware of his surrounding, where he was.

Q. And good and accepted medical practice requires you to perform this mental status examination of his cognitive functioning, correct?

A. That's correct.

Q. And to make a note of your findings, correct?

A. Correct.

Q. And make a note of your examination of his cognitive functioning, correct?

A. That's correct.

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Q. You indicated obstruction [sic], what is that?

A. Trying to test the intellectual capacity by giving problems or decision making if you give a situation.

Q. Did you perform this part of the mental status examination on Mr. Schoolcraft?

A. We do that in all of our patients. I may have done it [indicating].

Q. So you did it with Mr. Schoolcraft?

A. Yes.

Q. He is one of your patients, correct?

A. Yeah.

Q. And does good and accepted medical practice require you perform this obstruction [sic] test --

MR. CALLAN: Objection.

MR. RADOMISLI: Objection.

Q. -- mental status examination?

MR. CALLAN: Objection to the

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form of the question.

MR. SMITH: It's abstraction. You said obstruction. Let's rephrase that.

Q. Does good and accepted medical practice require you to perform this abstraction test?

A. Yes.

Q. And to make notes of your findings during that test?

A. Yes.

Q. Thought process, what is that?

A. Thought process.

Q. You said part of the test was thought process?

A. If he was thinking linear, is he goal directed or is he was over -- going [sic] disorganized or loose.

Q. Good and accepted medical practice requires you to perform that examination as part of your mental status examination?

A. Yes.

Q. And you make notes of your

findings, correct?

A. Yes.

Q. You talked about whether or not part of the mental status examination is whether or not someone is delusional?

A. Yes.

Q. How do you that?

A. Delusional is false belief.

Q. False belief?

A. That's not in agreement with one's culture.

Q. How do you perform that test?

A. You usually ask them or when the patient comes and say somebody running after me, somebody is chasing me, or there is a conspiracy or plot against me; that is a delusional belief, a false belief.

Q. How do you perform that test?

A. They come and tell you.

Q. You ask them?

A. The patient tells you.

Q. Have a conversation?

A. Yes.

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THE REPORTER: You have to slow down.

Q. And good and accepted medical practice requires you to make a note of that conversation, correct?

A. Yes.

Q. And to detail what the patient says, correct?

A. Yes.

Q. For each of your patients, correct?

A. Yes.

Q. And you did that with Mr. Schoolcraft, correct?

A. Yes.

Q. Suicidal tendencies, you said that was part of your mental status examination --

A. Yes.

Q. -- what did you mean?

A. We have to ask them if they were suicidal, contemplating, if they are -- if they have a plan.

Q. And does good and accepted

medical practice require you to make a note of their responses to those questions?

A. Yes.

Q. Did you ask Mr. Schoolcraft those questions?

A. Should have been asked. I'm sure asked.

Q. Should have been asked?

A. We ask for every patient.

Q. So you asked it of Mr. Schoolcraft?

A. Yes.

Q. Did you make a note of his responses?

MR. CALLAN: You can look at the chart.

Are you asking from her memory or --

Q. If you recall?

A. I do not recall if I did write it.

Q. But good and accepted medical practice would require you to make a note

of his responses to your questions regarding suicidal tendencies?

A. Yes.

Q. How about homicidal tendencies, how do you test for that?

A. When a patient comes and tell you he's has thoughts of hurting anyone, and then you will ask him if he has a plan, if he has a weapon.

Q. Did you do this test on Mr. Schoolcraft?

A. Yes.

Q. Did Mr. Schoolcraft have a plan or a weapon?

A. I will not remember.

Q. Did you make any notes? Does good and accepted medical practice require you to make a note of Mr. Schoolcraft's responses to your question regarding homicidal tendencies?

A. I will not remember.

Q. Does good and accepted medical practice require you to make that note --

A. Yes.

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Q. -- regarding Mr. Schoolcraft's response regarding homicidal tendencies?

A. Yes.

Q. And good and accepted medical practice requires you to make a note of both suicidal or homicidal representations that the patient makes to you as a physician, correct?

A. Correct.

Q. For every patient that makes representation about a method by which they were going to perform a suicide or a homicide, you would make a note of that, correct?

A. Correct.

Q. Because good and accepted medical practice would require you to make that note, correct?

A. That's correct.

Q. If there is no such note, the patient didn't say it, correct?

A. That's correct.

Q. If the patient did not express a suicidal tendency, you would not make a

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note of that?

MR. CALLAN: Objection to form.

MR. SUCKLE: I will rephrase it.

Q. If the patient did not express how they were going to perform some type of homicidal act --

MR. SUCKLE: I'm withdrawing that question too.

Q. When a patient expresses a suicidal thought, do you write down the details of that thought in --

A. Yes.

Q. Because good and accepted medical practice requires you to do that, correct?

A. Yes.

Q. And the absence of any note regarding homicidal thought in your records means the patient did not express a homicidal thought, correct?

A. It will say that the patient is not homicidal or they will put a negative sign, a circle.

Q. I'm talking about you in your

record.

A. Uh-huh.

Q. When a patient expresses how they intend to commit a homicidal act, do you write down the thought of the patient how they were going to commit the homicidal act?

A. Yes.

Q. When a patient expresses how they are going to commit a suicidal act, do you write down what the patient tells you about how they were going to perform a suicidal act?

A. That's correct.

Q. If there is no note regarding how a patient is going to commit a suicidal act, that means the patient didn't express to you how they were going to commit a suicidal act, correct?

A. Correct.

Q. If there is no note regarding how a patient was planing to commit a homicidal act, that means the patient didn't express to you how they were going

to commit a homicidal act, correct?

A. That's correct.

Q. You have to assess their speech. How do you do that?

A. Characterize the volume and the pitch: Is it soft, is it normal.

Q. And again, good and accepted medical practice requires you as a physician while performing this mental status examination to make a note regarding the assessment of speech, correct?

A. That's correct.

Q. Did you have access to Mr. Schoolcraft's entire chart when you first saw him?

Did you understand the question.

A. Yes.

Q. Physically, this chart we now have as Exhibit 69 in some form was fully accessible to you in the psychiatric emergency room when you saw Mr. Schoolcraft, correct?

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MR. CALLAN: Objection to form.

MR. SMITH: Objection to form. There is a timing issue.

Q. Was Mr. Schoolcraft's medical chart as it existed at the time that you saw him available to you at Jamaica Hospital's emergency room?

A. Yes.

Q. Did you have physically Mr. Schoolcraft's chart in your presence when you evaluated him?

MR. CALLAN: She already said yes to that, Counsel.

MR. SMITH: I don't think she did.

Q. Did you have it in your presence when you evaluated him?

A. I saw it before I saw him.

Q. Where were the charts keep in this psychiatric emergency room at least as it was in November 2009?

A. It's usually in the nursing station.

Q. Are you familiar with the

policies and procedures for Jamaica Hospital with regard to the use of restraints as they existed in 2009?

A. Yes.

Q. What is your understanding of that?

A. A restraint a usually applied on a patient who is a danger to himself or a danger to the other patients or someone is very agitated, aggressive, or violent.

They usually come in soft restraint, four-point restraints usually applied for two hours, and then staff has to go monitor those restraints every 15 minutes to make sure there is no impairment of circulation.

Q. You described a type of restraint. I missed what you said.

A. Soft restraint.

Q. What is a soft restraint?

A. They are not leather. They were like Velcro, like bandages, so that they wouldn't be very constricting to the

hand or the wrist of the patient.

Q. Are those the only type of restraints that Jamaica Hospital used in 2009?

A. Yes.

Q. And who makes the decision regarding whether or not restraints are to be applied to a patient?

A. When the doctor is not present, any nursing staff that's there can make a decision if the patient should be restrained.

What they do is call the doctor and they will tell the doctor that a patient is going to be restained, and in 30 minutes that doctor has to go and check the patient.

Q. When a patient was brought in in handcuffs at Jamaica Hospital in 2009, was there a procedure for assessment as to whether or not that person should be put into hospital restraints or not?

A. Repeat that again.

Q. Sure.

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When a patient was brought into the hospital, Jamaica Hospital, in handcuffs in 2009, was there a hospital procedure for determining whether or not that patient should be put in the soft restraints that you described?

A. Depends on the case. If the patient is in handcuffs taken to our emergency room and the patient is agitated or violent and a danger to that community of the ER, then he will have to be restained. We usually restrain those kind of patients, violent patients.

Q. When a violent patient comes in in handcuffs, they were then placed into the soft restraints, correct?

A. Yes.

Q. Why is that?

A. If they are violent, if we see them as a potential danger, then we have to restrain them.

Q. Are the only appropriate restraints to be used at Jamaica Hospital in 2009 the soft restraints that you have

been describing?

MR. RADOMISLI: Objection to form.

MR. CALLAN: I join the objection.

Q. Does good and accepted medical practice require when a patient was brought in in handcuffs that the hospital replace those handcuffs with soft restraints in 2009?

MR. RADOMISLI: Objection to form.

A. Not all handcuffs are soft restraints. I'm trying to say if we think they were violent and a danger or if they are going to be destructive, we have to put them in restraints.

Q. When you say not all handcuffed people are put in restraints, are all people that need to be restrained removed from handcuffs and put into soft restraints?

A. If they were violent.

Q. How soon after admission in

handcuffs should the patient be put into soft restraints?

A. They go through triage. If triage assess the patient and they assess that the patient needs to be on restraints because they were violent, as soon as they come into the emergency room, we have to take off the handcuffs and put them on four-point restraints.

Q. Why is that?

A. Because they are dangerous. That's after the assessment. If we know they are dangerous, we have to put them on restraints.

Q. Am I correct once a patient is brought into Jamaica Hospital in handcuffs and they become a patient of the hospital, physicians are going to make decisions about restraints and the type of restraints to be used, correct?

A. Yes.

Q. Not the police officers, correct?

A. No, they don't have a role.

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Q. When you say "they don't have a role," what do you mean?

A. They don't have a role in deciding if our patient should be restrained or not.

Q. If a patient is handcuff and the hospital wants the handcuffs removed, they should be removed, correct?

MR. RADOMISLI: Objection to form.

MR. CALLAN: Objection to form.

A. The handcuffs?

Q. Yes.

A. If we think they have to -- clarify that. There are many, many -- go ahead. Can you clarify it?

MR. SUCKLE: We will move onto something else.

Q. Did you have any role in writing any written rules or regulations with regards to restraints at Jamaica Hospital?

A. Do I have a role -- I may have sit in in one of those sessions, yes.

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Q. As a medical provider, your concern is for the patient's health, correct?

A. Yes.

Q. Did you in reviewing the chart -- how many times did you actually speak to Mr. Schoolcraft?

A. I speak to him once when I came in.

MR. SMITH: I'm sorry, what?

THE WITNESS: When I came in.

Q. When you say when you came in, when your shift started?

A. Yes.

Q. It's your understanding Mr. Schoolcraft was already in the hospital when your shift started?

A. Yes.

Q. Do you know how many other patients were under your care when you first started that shift at the psychiatric emergency room besides Mr. Schoolcraft?

A. I do not know. 2009 we usually

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have a 13-bed capacity. It's always full so I wouldn't know how many patients were there.

MR. SMITH: Did she say 30 beds?

THE WITNESS: Thirteen.

Q. Am I correct that the first time that you encountered Mr. Schoolcraft he was in the psychiatric emergency room, correct?

A. That's correct.

Q. I will show you what's been marked Plaintiff's Exhibit 69 for today's date. I will ask you, can you turn to the first entry that you made in this chart.

[Witness complying.]

A. [Indicating.]

Q. And you pulled out a note, what is the date of that note?

A. That was on November 2nd, 2009, three o'clock in the morning.

Q. Do you know what your shift was that day?

A. My shift was from eight to

four.

Q. And are you familiar with the any laws or rules regarding patients being held in psychiatric emergency rooms or hospital against their will?

MR. RADOMISLI: Objection to form. Can I just see that?

MR. CALLAN: [Handing.]

A. Clarify that.

MR. SMITH: Can I see that too?

MR. CALLAN: Let's get the notes straightened out.

Q. Just as a clarification, you said you made this note at three a.m.?

A. That's p.m.

Q. When did your shift start?

A. From eight to four.

MR. SMITH: A.m. or p.m.?

Q. 8 a.m. to 4 p.m.?

A. Yes.

Q. Are you familiar with any rules in the Mental Hygiene Law for admitting patients against their will?

A. Yes, the involuntary admission.

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MR. SUCKLE: Let me put a thing there so you don't lose it.

MR. LEE: I didn't hear anything you just said.

MR. CALLAN: His said he's putting a marker in the chart so she doesn't lose her place.

Q. What do you know of that law?

A. That is where two doctors will commit the patient, or we have the 9.39 which is the emergency admission.

Q. What was the first one?

A. Involuntary, that would be the 9.27, and emergency admission is the 9.39.

Q. What is 9.27, what does that mean?

A. Involuntary admission.

Q. That's somebody going to be involuntarily admitted for how long?

A. After 48 hours, that depends if the patient is not better, they can be kept until six months.

Q. So 9.39 of the Mental Hygiene

Law, what is that?

A. Emergency admission to the hospital which is also involuntary.

Q. In order for a patient to be involuntarily admitted to a hospital, are you familiar with the procedure that must take place?

A. Yes.

Q. Did you learn about this in your training at Jamaica Hospital?

A. At Metropolitan Hospital.

Q. And you have been familiar with that since your training at Metropolitan Hospital?

A. Yeah.

Q. Have you ever had to use that involuntary -- that 9.39 of the Mental Hygiene Law to admit a patient?

A. Yes.

Q. How many times have you done that in your career?

A. Many times.

Q. When you say "many," give me an idea how many is many?

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A. At that time I used to see 3,000 patients a year, most likely 2,000 patients. I'm giving you a....

MR. SMITH: Can you read that back.

[The requested portion of the record was read.]

A. An approximation.

Q. Is that 2,000 patient a year?

A. Two thousand patients a year.

Q. You used Section 9.39 of Mental Hygiene Law to admit patients against their will 2,000 times in the year 2009, correct?

A. Most likely, yes.

Q. The 2,000 per year, has that basically been about how many you have admitted per year while you work at Jamaica Hospital to date?

A. Cannot recall. It's hard to say.

Q. This is a regular occurrence in your practice?

MR. CALLAN: Objection to the

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form of the question.

Q. Do you understand my question?

A. [No response.]

Q. Do you understand my question?

A. Say it again.

Q. Sure.

Admitting a patient pursuant to 9.39 of the Mental Hygiene Law is a regular part of your practice, correct?

A. Yes, when I was in the emergency room.

Q. And does your understanding of 9.39 of the Mental Hygiene Law, does that apply to any admission at Jamaica Hospital or just the psychiatric emergency room?

A. Just the psychiatric emergency room.

Q. So a patient can be held against their will in the medical emergency --

MR. RADOMISLI: Objection to form.

MR. LEE: Objection to form.

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MR. CALLAN: I join in the objection.

Q. Without complying with 9.39 --

MR. CALLAN: Objection.

Q. Is that your understanding?

A. I could admit them involuntarily, yes.

Q. So a patient can be admitted pursuant to 9.39 of the Mental Hygiene Law in the medical emergency room, correct?

A. In the medical emergency room?

MR. CALLAN: Objection to the form of the question.

Q. Yes.

MR. CALLAN: You can answer.

THE WITNESS: I can answer?

MR. CALLAN: Yes.

A. If the patient is in the medical ER and we know that the patient needs to be transferred to the psychiatric ER, then we have to move them from the medical ER to the psychiatric ER.

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Q. If someone is in the medical emergency room --

A. Yes.

Q. -- are they free to leave?

A. From the medical ER?

Q. Yeah.

A. But that depends, yes.

If the medical doctor calls for an evaluation or assessment for a psychiatric patient, if the psychiatric doctor deems the patient -- that the patient needs to be transferred to the psychiatric ER, they were not free to leave. They have to come to the psychiatric ER.

Q. So it's your understanding a patient in the medical ER can be held until transferred to the psych ER for the purposes of then being evaluated at some point in the psych ER under Section 9.39 of the Mental Hygiene Law; is that your understanding?

MR. LEE: Objection to form.

MR. RADOMISLI: Objection.

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MR. CALLAN: Same objection.

A. A psychiatrist will go to the medical ER, he will assess the patient. He already assessed and evaluated. The psychiatrist will say once medically cleared, transfer the patient to the psych ER. So then the patient will be in the psych ER.

Q. When a patient is in the medical ER --

A. Yes.

Q. -- and they want to go home, can they go home?

A. It depends. If a medical issue, yes. If medically cleared they want to go home, they go home.

If a psychiatric issue and the psychiatrist will say send to the psych ER, then cannot go home. They have to come to the psych ER for further stabilization or further assessment.

Q. Under what standard or law, rule or regulation can a person be held, to your understanding, in the medical

emergency room pending transfer to the psych emergency room?

A. If you are referring to that, there is no 9.39 or 9.27 or 9.13.

If we know that the patient needs to come to psychiatry, we have to transfer the patient to psychiatry.

Q. Am I correct that the only way a hospital can hold a patient based upon a psychiatric problem is under 9.39 if that patient wants to go home?

MR. LEE: Objection to form.

MR. CALLAN: Objection to form.

MR. RADOMISLI: Objection to form.

A. Rephrase your question.

Q. Sure. I will rephrase it.

You say when a person is in the medical emergency room, they can be held. What does that mean?

A. If let's say the medical doctor will ask for a consult, he needs a psych consult because let's say that patient is behaving bizarre or may be agitated in

the ER or if they have a past history of psychiatric illness, then that doctor will call for a psychiatrist to come and see the patient.

If the psychiatrist thinks that the patient needs to be transferred to the psychiatric department, then we can hold the patient and transfer that patient to the psychiatric unit.

Q. Under what regulation, rule, or standard can you hold the patient that you're aware of that you just described?

A. There is no 9.39, it's the decision of the psychiatrist to transfer. That's the medical ER. Usually, in the medical ER you cannot handle the patient that has all of these symptoms that I was talking about: bizarre behavior, violent, unpredictable, delusional.

They can't handled those types of patients. They tend to transfer that patient to the psychiatric unit for further stabilization of the psychiatric problem.

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Q. I'm going to ask my question again. Maybe I'm not being clear.

Under what rules, standard, or law can a patient be held in a medical emergency room pending transfer to the psychiatric emergency room for evaluation of the Mental Hygiene Law 9.39, if you are aware of any?

A. I'm not aware of any.

Q. Am I correct that Section 9.39 of the Mental Hygiene Law as you understand it must be complied with in order to hold a patient for psychiatric reasons against their will?

MR. LEE: Objection to form.

A. That is for when you admit the patient?

Q. Yes.

A. 9.39.

Q. That's your understanding?

A. Yes, that's against the rule, yes.

Q. What is required by Section 9.39 of the Mental Hygiene Law as you

understand it in order to admit a patient against their will under that section?

A. If we know that the patient need admission because they are a danger to themselves or a danger to society; if they are psychotic and not able to take care of themselves; if they were depressed; if they were suicidal, then we make that decision that the patient needs to be admitted even if it's against their will.

Q. This assessment that you just said has to be made, is that the kind of assessment we talked about earlier: the mental status examination?

A. Yes. Yes.

Q. And when a person is depressed, when you say they could be held, what do you mean?

A. They could be held?

Q. Yeah, because they are depressed?

A. When they were depressed and not able to take care of themselves, then

that would be considered also a danger to themselves because they were depressed. They are not functioning, not eating. They could be suicidal. They were not maybe functioning, to bare minimum. They are not sleeping, not eating. This is also considered a danger to themselves so they have to be admitted.

Q. Are there certain procedures that must be followed in order to comply with 9.39 as you understand it?

A. Patient not able to take care of themselves then we are supposed to admit these patients.

Q. As a physician are there certain things that you are supposed to do in order to comply with Section 9.39 of the Mental Hygiene Law as you understand it?

A. Yes, I have to admit this patient. They are depressed.

Q. That's all you have to do is admit them?

A. I have to admit them, observe

them, stabilize them, medicate them.

Q. Anything else that you have to do?

A. Anything else. I have to stabilize, medicate. I have to admit. I have to obtain information from previous records.

Q. What kind of previous records, you mean the hospital records?

A. Yes. If they have a psychiatrist, I have to call them.

Q. If they have a psychiatrist, you have to call them?

A. If they have a psychiatrist, yes.

Q. What about any other doctor, do you have to call those doctors?

A. Only the psychiatrist.

If they say they want us to call their medical doctor, yes, we call their medical doctor.

Q. Did you have to fill out any form?

A. Yes, release of information,

yes.

Q. In order to comply with Section 9.39 of the Mental Hygiene Law, you have to fill out a release of information form?

A. I have to go back. I'm sorry.

In the emergency room, we do not get release of information, only in the inpatient unit.

Q. Did you ever fill out any form in order to comply with Section 9.39 of the Mental Hygiene Law, as you understand it?

A. Just those forms, the 9.39 form.

Q. What are those forms for?

A. Those are legal forms.

Q. What is the purpose of those legal forms, do you know, as you understand it?

A. The purpose of those legal forms is just for the reason that you think: if the patient is a danger to himself and that he needs to be

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stabilized in a hospital.

Q. It's for your own benefit?

A. No.

MR. CALLAN: Objection to form. You're recharacterizing her answers.

MR. SUCKLE: I'm asking.

A. It's not for my benefit.

Q. Whose benefit is it for?

A. For the benefit of the whole society as well as the patient and whole society.

Q. Is it important to be accurate in your recordkeeping in a hospital chart?

A. Repeat the question.

Q. Is it important to be accurate in your recordkeeping and note keeping in a hospital chart?

A. Yes.

Q. As a physician?

A. Yes.

Q. Why?

A. It's for the sake of patient.

MR. SUCKLE: Do you need to take

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a break?

THE REPORTER: No.

MR. SMITH: Let's take a break. We are going off the record at 11:51.

[Discussion held off the record.]

[Whereupon, at 11:51 a.m., a recess was taken.]

[Whereupon, at 12:13 p.m., the testimony continued.]

MR. SMITH: Back on the record 12:13.

Q. Doctor, you had indicated to us your first note in the chart was November 2nd, 2009, at 3:10 p.m.

And do you know whether or not the patient had been evaluated from a psychiatric prospective at any time prior to your note?

A. You're asking me if --

Q. I'm asking do you know whether or not the patient had to be evaluated from a psychiatric prospective at any

time prior to November 2, 2009, at any time before you made your note?

A. Yes.

Q. Did you review the chart of Mr. Schoolcraft prior to seeing him on November 2nd, 2009, at 3:10 p.m.?

A. Yes.

Q. Why did you do that?

A. To be able to know the patient and see what's going on and get information about the patient.

Q. And when for the first time did anybody do any kind of psychiatric examination or assessment of Mr. Schoolcraft in Jamaica Hospital that you're aware of?

A. That is when he was in the medical ER.

Q. And did you see a note of that evaluation?

A. Yes, it's here [indicating].

Q. What is the date and time of that note?

A. It's 11/1/2009 at 6:30 in the

morning.

MR. LEE: At what time?

THE REPORTER: 6:30 in the morning.

MR. SUCKLE: Just give me a second.

MR. SMITH: Did you see 11/1?

THE WITNESS: Yes, 11/1/2009 at 6:30 in the morning.

Q. And this is a note by who?

A. Dr. Lewin.

Q. Spell that?

A. L-E-W-I-N.

Q. It says 1 of 3 on top, correct?

A. Yes.

Q. It's a three-page note, correct?

A. Yes.

Q. And it ends and the three pages end with a note on 11/1/09 at 6:30 a.m., correct?

A. Yes.

Q. This is called a "Consultation Form." What is that?

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A. When the doctor calls for a consult, this is the form that we use to write our notes.

Q. What was the purpose of having Mr. Schoolcraft evaluated, if you recall, from your review of the chart?

A. Okay. It said in here that a psych consult was called and reported as patient was acting bizarre.

Q. Did you read this note prior to your evaluation of the patient?

A. Yes.

Q. Is this one of notes that you read prior to coming here to testify in preparation for your testimony today?

A. Yes.

Q. And were you able to read the note, the handwriting, when you read it --

A. Yes.

Q. -- back in 2009?

A. Yes.

Q. Have you seen Dr. Lewin's handwriting before?

A. Yes.

Q. And you had become familiar with it?

A. Yes.

Q. And if you go to the second page of that note, did you see from that note there had been no prior psychiatric history?

A. It says in here, "Denied past psych hospitalization or treatment."

Q. Or suicidal attempt?

A. Yes.

Q. And after this note was written, was Mr. Schoolcraft free to go home?

A. After this note was written, she had recommendations.

Q. I know. But my question was: Was Mr. Schoolcraft free to go home after that note was written?

A. No.

Q. When you say "no," why not?

A. Because then that was her recommendation he needed one-to-one

observation for unpredictable behavior and escape risk.

Q. What was he escaping from, what was the escape risk from?

A. He might run out of the emergency room because it's unlocked door.

Q. He needed to be held because he was an escape risk?

A. He needed to be observed more.

Q. He needed to be observed more?

A. One-to-one, yes.

Q. Did you also read in the note on the second page, the last line on the second page where the note reads, "He denies suicidal ideations." Do you see that?

A. Yes.

Q. And "He denies homicidal ideations."

A. Yes.

Q. Do you have any reason when you read that note to believe that wasn't true?

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MR. LEE: Objection to form.

A. But you are missing the point in there when he is paranoid about his supervisors.

Q. I asked you whether you had any reason to believe he was not suicidal and not homicidal?

A. I think I need to know further if he was suicidal or homicidal. At that point in time, I need to assess suicidal or homicidal.

Q. You didn't have enough information by just reading suicidal or homicidal, correct, you needed more information, correct?

A. Yes, it's saying here he was paranoid about his supervisors.

MR. CALLAN: Objection to form.

Q. So he was being held because he was paranoid?

A. Not only that. He became agitated, uncooperative, verbally abusive while he was in the medical ER so we have to find out why there is agitation, why

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is was behaving bizarre.

Q. Just so I understand. He is been held because he is agitated?

A. Yes.

MR. CALLAN: Wait for the question.

Q. He was being held because you want to know more about him, correct?

MR. CALLAN: Objection to form of the question.

Q. Is that correct?

MR. CALLAN: That question doesn't make any sense. You are talking about --

MR. SUCKLE: You have your objection.

Q. Is that your understanding of the note?

A. There was more to that. The patient was behaving bizarre.

Q. What action was he taking that was bizarre?

A. According to the note, when they went to his house, the patient

barricaded himself and he will not open the door so they had to break into his apartment.

Q. Is it your understanding under 9.39 of the Mental Hygiene Law, someone can be held because they are acting bizarre?

MR. CALLAN: Objection to form.

MR. LEE: Objection to form.

Q. Is that your understanding?

A. That's my -- he can be bizarre and he can be psychotic.

Q. The question was: Is it your understanding of 9.39 of the Mental Hygiene Law that a patient could be held because they're acting bizarre?

MR. LEE: Objection to form.

A. He can be a danger to himself.

Q. You have to answer my question. Can a patient be held under Section 9.39 of the Mental Hygiene Law because they are acting bizarre?

A. Yes.

Q. Can they be held under Mental

Hygiene Law 9.39, as you understand it, because they are agitated?

A. Yes.

Q. That's your understanding of the law?

MR. CALLAN: Objection to the form of the question.

Q. Correct?

A. [No response.]

Q. Am I correct that's your understanding?

A. My understanding, yes.

Q. So a good and accepted medical practice as you understand it allowed to make a hospital to hold Mr. Schoolcraft on November 1, 2009, 'cause he was acting bizarre, correct?

MR. CALLAN: Objection to form.

MR. LEE: Objection to the form.

Q. Correct?

A. It's not only the behaving bizarre. It's the whole picture that was going on at the time. From the --

Q. Did you see anything in this

note that Mr. Schoolcraft was exhibiting a threat to another person?

A. Not a threat to another person.

Q. Did you see anywhere in here that he was suicidal?

A. He is not suicidal.

Q. Did you see anywhere in here that he was going to harm himself in any way?

A. That I have to question if he was going to hurt himself or if he was a danger to himself because if I have somebody in the emergency room, you have a report that he was behaving bizarre or he was agitated, and if I look at the whole picture from the time that he was taken away from his home where he was -- he barricaded himself, then I have to consider him to be held against his will.

Q. Did you see anything in this record that Mr. Schoolcraft indicated to the consulting physician that he was going to harm himself?

A. He said in here that he denied

that he was going to hurt himself. There is nothing that he was going to hurt himself.

Q. Or hurt anybody else, correct?

A. Nope.

Q. Do you know the physician, the psychiatric resident, that signed that note?

A. That is Dr. Lewin. The resident was Dr. Lewin, and the attending Dr. Patel.

Q. On the last page of that note, it's a three-page note, is there a stamp there for the resident?

A. Yes.

Q. So Dr. Lewin was a resident?

A. Yes.

Q. And did Dr. Lewin provide any notice to Mr. Schoolcraft under 9.39 of the Mental Hygiene Law?

MR. RADOMISLI: Objection.

A. I would not remember that.

Q. Did Dr. Lewin, from your review of the records, produce any forms, signed

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any form, under 9.39 of the Mental Hygiene Law in order to admit Mr. Schoolcraft against his will?

MR. RADOMISLI: Objection.

Q. Did you see any form?

MR. RADOMISLI: Objection.

MR. CALLAN: Objection.

Q. Did he fill out any such form?

MR. CALLAN: She is supposed to get into his mind and know what he did?

MR. SUCKLE: Forms, forms, did you see any forms.

MR. CALLAN: Did you see any forms, that's fine.

Go right ahead.

A. No.

Q. Is there anything in the file that suggests that Dr. Lewin actually filled out any form with regard to 9.39 of the Mental Hygiene Law?

MR. RADOMISLI: Objection.

Q. Anything to suggest that?

MR. RADOMISLI: Objection.

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Q. From your prospective?

MR. RADOMISLI: Objection.

MR. SUCKLE: I heard it.

MR. RADOMISLI: I strenuously object.

MR. SUCKLE: I heard your strenuous objection.

MR. CALLAN: Do you want her to look through the entire record?

A. There are no forms.

Q. Did Dr. Lewin, do you see anything to suggest that Dr. Lewin then ensured within 48 hours that another physician evaluated Mr. Schoolcraft?

MR. RADOMISLI: Objection.

MR. CALLAN: Objection.

Q. Does it say anything in there?

A. She indicated in here he needs to be transferred to the psych ER.

Q. And after Dr. Lewin, there is another signature. Do you know who that is? Did I ask you that already?

In the note of November 1, that Dr. Lewin wrote, underneath his signature

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is another signature. Do you know whose signature that is?

A. That is Dr. Patel.

Q. Did Dr. Patel fill out any form that you are aware of in order to comply with 9.39 of the Mental Hygiene Law?

MR. LEE: Objection to form.

MR. RADOMISLI: Objection.

MR. CALLAN: Same objection.

Q. No?

A. There is no form in here.

Q. There is no form in the record, correct?

A. None.

Q. Did you read Dr. Patel's note at the end there where he signed?

A. "I concur with above doctor's treatment recommendations."

Q. What is psychotic disorder, what is that?

A. Psychotic disorder is one of the categories of diagnosis wherein patient is not in touch with reality.

He can have the following

symptoms, like, agitation, aggressive behavior, delusions, hallucinations, impairment in reality testing.

Q. That's a pretty broad category, correct?

A. Yes.

Q. What does Axis I stand for?

A. Those are our DSM categories when we are diagnosing patients.

Axis I is for psychotic disorders or mental health disorders. Axis II would be our personality disorder. Axis III is the medical disorder. Axis IV is the social stressor. And Axis V is the global functioning.

Q. So when you read that note, you learned that there was some social stressors; being, a conflict at the worksite for Mr. Schoolcraft, correct?

A. That's correct.

Q. Do you know what the nature of a that conflict was?

A. Something -- a conflict between